VOIDING / PVR DIARY

(Self-Catheterization)

PATIENT NAME: _____ DATE: _____

BEDTIME: _____ TIME YOU GOT UP FOR THE DAY: _____

TIME OF VOID	STRENGTH OF PAIN OR URGE (RATE 0 TO 10)		VOIDED VOLUME (CC)	CATHETER VOLUME **PVR** (CC)	COMMENTS OR ANY ADDITIONAL INFROMATION YOU CAN GIVE US